

MDR Tracking Number: M5-04-0902-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 11-25-03. Dates of service 11-21-02 through 11-22-02 were not timely filed per Rule 133.308(e)(1).

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening on 11-26-02 through 12-20-02 was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 11-26-02 through 12-20-02 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 21st day of January 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

January 14, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

This is a 65 year old gentleman who on ___ sustained an injury to the shoulder and lumbar spine. The shoulder was surgically treated in 1997 (there is a dearth of medical records related to that event). At the time of shoulder surgery there was a noted "severe" degenerative arthritis of the shoulder. What transpired between January 1997 and August 2002 is not clear. In February 2002 a neurosurgical evaluation noted a problem with the cervical spine. Also of note is that ___ identified that the claimant "has not been working due to other medical problems". Chronic pain issues were addressed. In August 2002 ___ was taken to the operating room for a two level laminectomy. Post-operative physical therapy and rehabilitation was completed. In November he was entered into a Work Hardening program. No FCE was presented for evaluation of the need for this program

REQUESTED SERVICE(S)

Work hardening program.

DECISION

Deny.

RATIONALE/BASIS FOR DECISION

This is a 65 year old, obese gentleman with a ___ injury to the bilateral shoulders and lumbar spine; with a history of severe degenerative arthritis, hypertension, hypercholesterolemia, obesity, diverticulosis, and benign prostatic hypertrophy who sought out a work hardening program in 2002. There is information that he had retired from his position and was seeking a position as a security officer or some other sedentary type job. A review of the medical records does not note any psychiatric malady that would require group of any psych services that are part of a work hardening program. In addition, there is no identification of an FCE documenting an inability to meet the demands of the position being sought and not the position held and retired from. Given that there was no position to return to, and that the 10/31/02 progress notes reflect that he was directed to a home

exercise program, and another progress notes also dated 10/31/02 sent ____ to work hardening without the benefit of a FCE, and the 12/12/02 progress notes simply direct him to a home exercise program; there is no clinical indication for the need for a work hardening program. Lastly, given the multiple medical problems identified, and that no trial of a modified work conditioning program or lower levels of care were attempted, the use of a work hardening program is felt to be premature, excessive and not medically reasonable and necessary care for the injury.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 16th day of January 2004.